

NOTIFICATION OF VOCATIONAL SERVICES by Private Rehabilitation Specialist

**Department of Workforce Development
Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
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Return completed copy: One to insurance company (or self-insured employer) and one copy to Worker's Compensation Division.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

EMPLOYEE	WC Claim Number		Employee Name	
	Social Security Number*		Employee Address (Number, Street, City, State, Zip Code)	
	Injury Date	Date of Birth	Telephone Number ()	
	Employer Name			
	Diagnosed Disability/Injury			
	Employee's Work Restrictions/Limitations			
INSURER	Insurance Company			
	Mailing Address (Number, Street, City, State, Zip Code)			
	Claim Representative		Telephone Number ()	
VOCATIONAL REHABILITATION SPECIALIST	Name (Please print)			
	WCD Certification Number		Telephone Number ()	
	Agency Name			
	Mailing Address (Number, Street, City, State, Zip Code)			
Check Services Planned: <input type="checkbox"/> Vocational Evaluation <input type="checkbox"/> Job Placement <input type="checkbox"/> Retraining Plan Development <input type="checkbox"/> Other (Describe): _____				
This is notification that I have been selected by the above-named individual to provide necessary vocational rehabilitation services to help that individual return to work.				
Vocational Rehabilitation Specialist Signature			Date Case Opened	